girl scouts of the northwestern great lakes

CAMP HEALTH HISTORY FORM

The Troop Leader must retain a copy of Health History Form for each troop member and keep ALL information CONFIDENTIAL.
Adults completing this form may sign for themselves on the Parent/Guardian signature line. Submit this form to camp staff on the first day.
PARTICIPANTS WILL NOT BE ABLE TO ATTEND CAMP WITHOUT THIS COMPLETED FORM.

Name: Last First Middle D.O.B. Age

Street Address City/State/Zip Male Female

Custodial Parent/Guardian ( ) Day/Work Phone ( ) Evening/Home Phone ( ) Cell/Mobile Phone

2nd Parent/Guardian ( ) Day/Work Phone ( ) Evening/Home Phone ( ) Cell/Mobile Phone

Street Address City/State/Zip

If not available in emergency, notify Relationship ( ) Phone

Insurance Information: Is the participant covered by family medical/hospital insurance? ☐Yes ☐No

If yes, indicate carrier or plan name______________________________ Group #_____________ ♦Photocopy of front and back of health insurance card must be attached to this form.

ALLERGIES: (or special dietary needs) (medication, food, or other allergies)

Describe reaction and management of the reaction.

GENERAL QUESTIONS (Explain "yes" answers below.)

	Has/does the participant	Yes	No			Yes	No
1.	Had any recent injury, illness or infectious disease?			15.	Ever been diagnosed with a heart murmur?		
2.	Have a chronic or recurring illness/condition?			16.	Ever had back problems?		
3.	Ever been hospitalized?			17.	Ever had problems with joints (e.g. knees, ankles)?		
4.	Ever had surgery?			18.	Ever had high blood pressure?		
5.	Have frequent headaches?			19.	Have any skin problems (e.g., itching, rash, acne)?		
6.	Ever had a head injury?			20.	Have diabetes?		
7.	Ever been knocked unconscious?			21.	Have asthma?		
8.	Wear glasses, contacts or protective eyewear?			22.	Have mononucleosis in the past 12 months?		
9.	Ever had frequent ear infections?			23.	Had problems with diarrhea/constipation?		
10.	Ever passed out during or after exercise?			24.	Have problems with sleepwalking?		
11.	Ever been dizzy during or after exercise?			25.	If female, have an abnormal menstrual history?		
12.	Ever had seizures?			26.	Have a history of bed-wetting?		
13.	Ever had chest pain during or after exercise?			27.	Ever had an eating disorder?		
14.	Have an orthodontic appliance being brought to the program?			28.	Ever had emotional difficulties for which professional help was sought?		

Please explain any "yes" answers, noting the number of the questions:____________________

Please give all dates of immunization for:	Month/year	Month/year	Month/year	Month/year	Month/year	Month/year
DTP						
TD (tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
Or Measles						
Or Mumps						
Or Rubella						
Haemophilus influenza B						
Hepatitis B						
Varicella (chicken pox)						

Which of the following has the participant had?

☐ Measles ☐ German measles ☐ Chicken Pox ☐ Mumps
☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which we should be aware:

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Complete this portion of the Health History Form if participant is attending camp.

This section requires the signature of licensed medical personnel.

PHYSICAL EXAM INFORMATION

The Physical Exam Information section of this form is required for ALL girls attending a wilderness trip program at Camp Birch Trails.

A physical exam must be completed by approved licensed medical personnel at least every two years (if you would like to use this form more than one year, ***please keep a copy in your records****).*

Health Care Recommendations by Licensed Medical Personnel

Date of Exam   Blood Pressure   Weight   Height

In my opinion, the above applicant is able to participate in an active camp program: ☐ Yes or ☐ No

The applicant is under care of a physician for the following conditions: ______

Recommendations and Restrictions at Camp

Treatment to be continued at camp: ______

Medications to be administered at camp (name, dosage, frequency): ______

Any adverse reactions to medications?: ______

Any medically prescribed meal plan or dietary restrictions: ______

Known allergies: ______

Description of any limitation or restriction on camp activities: ______

Additional information for health care staff at the camp: ______

Signature of Licensed Medical Personnel:

( )

Printed   Title   Phone   Date

Street Address   City/State/Zip

Important – SIGNATURE REQUIRED FOR ATTENDANCE

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp / Girl Scouts of the Northwestern Great Lakes, Inc. to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp / Girl Scouts of the Northwestern Great Lakes, Inc. to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp / Girl Scouts of the Northwestern Great Lakes, Inc. to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of Parent or Guardian or Adult Volunteer/Camper/ Staffer   Date